HCFA MEDICARE • MEDICAID Health Care Financing Administration

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HEALTH watch

Restraint-Reduction Focus of National Conference

HCFA's Philadelphia Regional Office recently took the first step to reach out beyond the audiences of nursing home industry representatives, medical professionals, and government employees in its restraint-reduction efforts.

At a conference entitled "How to Get Nursing Home Residents Out of Restraints," over 100 consumer and elder advocacy group representatives from around the country received an overview on restraint-reduction efforts. Attendees were encouraged to share their knowledge of the new approaches in restraint-free care with others in the community.

In her keynote address, Sarah Greene Burger, Associate for Program and Policy at the National Citizen's Coalition for Nursing Home Reform, presented a historical perspective on the effects of restraint use. Ms. Burger also addressed why and how to remove restraints, how to address behavioral problems in medical facilities without resorting to chemical restraints, and psychoactive drugs which are appropriate or inappropriate to use.

Sarah Greene Burger speaks on the effects of restraint use.

In the next few months, HCFA will follow up with conference participants to find out about restraint-reduction activities planned at the local level. This is part of the agency's national efforts to track the restraint-reduction initiative. For more information on the conference or restraint-reduction issues, please contact Jerry Arzt at 215/596-6952 ***(e-mail: jarzt@hcfa.gov).***

Organ Transplant Hearing Sparks Debate

HCFA Administrator Bruce Vladeck joined organ transplant professionals, patient advocates, ethicists, and other DHHS officials at a public hearing in early December to discuss organ allocation processes and proposals to increase organ donation rates. Officials from the Department will consider testimony from the hearing in assessing DHHS oversight of the Organ Procurement and Transplantation Network (OPTN).

A key issue the Secretary is considering is the fairness of a new liver allocation and classification system developed by the OPTN. The new policies would change the allocation of livers by reclassifying chronic liver disease patients in terms of priority for transplant. In addition, the new policy would largely retain a controversial "local first" approach to liver allocation. Another important issue raised is the need to increase organ donation rates. Several individuals recommended that the Secretary take an active role in promoting and facilitating organ donations. (Continued on page 5)

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HCFA HEALTH watch

The *HCFA Health Watch* is published monthly, except when two issues are combined, by the Health Care Financing Administration to provide timely information on significant program issues and activities to its external customers.

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Thank You!

Thanks for responding to *HCFA Health Watch's* Reader Survey.
Your responses will help us to develop story ideas and address issues that are important to you, our readers.
If you have any further suggestions or questions regarding the *Health Watch*, please contact one of the team members listed above.

Message from the Administrator

BRUCE C. VLADECK

Medicare and Medicaid, since their inception, have worked to protect the interests of beneficiaries. We are taking new steps to continue to protect their interests as more and more people move into managed care.

These are some of the specific actions we are taking:

❒ *Banning "gag clauses" in managed care contracts with physicians*. Some plans have been accused of prohibiting physicians from telling patients about services not covered by the plan. We sent a letter to managed care plans in November explaining that federal law and regulations entitle Medicare beneficiaries to the full range of their physicians' opinions and counseling about medically necessary services.

❒ *Limiting financial incentives that put physicians' income at "substantial risk."* Many managed care plans pay physicians a set fee per patient and require the physician to provide all needed care. Some plans provide bonuses to physicians if the cost of care to the plans' patients does not exceed certain limits. Critics contend these bonuses create incentives to withhold necessary care. We have implemented new rules to protect physicians from excessive risk where the cost of care for their patients exceeds what they are paid by the plan.

❒ *Requiring plans to report state-of-the-art measurement of their performance and conduct member satisfaction surveys*. Determining how well plans are doing at providing high quality care is a difficult but rapidly evolving science. We now require Medicare managed care plans to report Health Plan Employer Data and Information Set (HEDIS) data. HEDIS has become the industry standard for measuring plans' performance. It now includes several measures of specific interest to Medicare beneficiaries. We are also requiring plans to conduct member satisfaction surveys.

❒ *Strengthening rights of beneficiaries to appeal managed care plan decisions to deny specific treatments*. Medicare beneficiaries already are guaranteed better appeal rights than members of most private sector managed care plans. We are developing even stronger protections to ensure that patients get prompt and objective review of decisions to deny specific treatments. These new rules will be released in the form of proposed regulations for public comment in the near future.

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HCFA Focuses on Top Beneficiary and Provider Questions

Do you know what beneficiaries are asking about? Are you aware that providers and beneficiaries ask basically the same questions? The answers to these questions and more are being studied as part of a current HCFA On-Line initiative. The "Top Issues" initiative focuses on developing a system to routinely collect information on the issues that most concern our customers and then use the findings to provide feedback to program staff members.

In an initial survey of customer inquiries taken by HCFA offices, contractors, and partners, "Billing Inquiries" (requests for information on how an account is billed or a simple clarification of a billing issue) were of most concern for both beneficiaries and providers. Rounding out the top five issues of interest to beneficiaries include: (1) Inquiries about Medicare publications; (2) "Other types of inquiries" including long-term care issues, home health care, ambulance coverage, qualified Medicare beneficiary programs; (3) "Medicare-Other" — a catch-all category that includes Medicare-related queries about check issues, dates of death and premiums; and (4) Medicare-Secondary Payer issues.

In addition to billing questions, the top five issues identified from provider inquiries include: appeals, "Other types of inquiries," "Medicare-Other," and billing complaints. Billing inquiries comprised 40 percent of all partner responses, while claims-oriented issues accounted for more than 77 percent.

If you would like to obtain more information about HCFA's Top Issues List, please contact Frank Sokolik, Director, Office of Beneficiary Relations, (410) 786-3205 ***(email:fsokolik@hcfa.gov)*** or Megan Arts, HCFA On-Line (410) 786-7321 ***(email:marts@hcfa.gov).***

Upcoming Events of February-March

Feb. 5

Administrator Bruce C. Vladeck speaks at Boston (Mass.) University on *Medicare and Medicaid vis-a-vis managed care predictions for the future and implications for health care managers.*

Feb. 26

Administrator Vladeck speaks at the Hebrew Rehabilitation Center for the Aged in Boston, Mass., on *Trends in aging care by the Year 2007 — what services the Center should be providing by then.*

Feb. 27

Administrator Vladeck addresses PHS-HRSA's Third National Primary Care Conference in Washington, D.C., on *The federal role in financing primary care education; policy issues with which HCFA is concerned.*

March 3

Administrator Vladeck speaks at HCFA/CDC and the National Coalition for Adult Immunization's Second Annual Influenza and Pneumonia Immunization Conference in Chicago, Ill., on *The importance of the flu/pneumonia immunization initiative.*

March 12

Administrator Vladeck speaks at Princeton University's Woodrow Wilson School of Public and International Affairs in Princeton, N.J., on *Cost control issues.*

March 21

Administrator Vladeck speaks at the international conference in Florence, Italy, on *Implementation and management lessons learned from Medicare.*

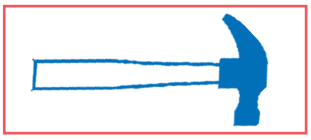
March 26

Administrator Vladeck addresses the American Society on Aging in Nashville, Tenn., on *How current and proposed health care policies may affect the delicate but enduring contract between parent and child.*

Immunization Conference

HCFA, the CDC, and NCAI are co-sponsoring a conference, "Partnering to Promote Adult Immunization" at the Sheraton Hotel in Chicago, Ill. Sessions will focus on how to run immunization campaigns, media coverage, and targeting underserved beneficiaries and providers. The conference is targeted toward PROs, carriers, intermediaries, managed care plans, provider organizations, professional and beneficiary groups, and federal agencies. For more information, call Kirsten Bianchi at Casals & Associates, 703/920-1234.

Teleservice Project Receives Hammer Award



In recognition of efforts to improve customer service, HCFA's Medicare Teleservice Project was recently awarded the Vice President's prestigious Hammer Award. The project, based in the Philadelphia Regional Office, focuses on enhancing telephone service to Medicare beneficiaries and providing them with necessary program information and assistance.

Since Medicare beneficiaries are elderly and/or disabled, they often use the telephone when in need of help or information. Staff members who work in the teleservice unit handle a percentage of Medicare-related telephone calls transferred from the Social Security Administration's Teleservice Center. With access to specific databases, HCFA teleservice staff can answer almost any Medicare-related inquiry from a customer.

Customer feedback on the teleservice center has been positive and assessment surveys show satisfaction rates in excess of 99 percent. Because of the usefulness and positive response to this project, it accomplished the objective of the Hammer Award — to build a government that works better and costs less.

Medicare Beneficiaries Are Assured of Rights to Physicians' Advice

Medicare managed care plans may not deter physicians from providing information to patients regarding all medically necessary treatment options, HCFA said recently.

In a consultative letter to more than 300 managed care plans contracting with Medicare, HCFA said that contract clauses limiting what physicians may tell Medicare beneficiaries violate federal law.

"No beneficiary should be denied the information they need to make a sound, informed decision on their treatment," said HHS Secretary Donna E. Shalala.

Patients and their doctors must have a free exchange of information.

Without question, many managed care organizations in recent months have agreed that "gag clauses" limiting discussion of medically necessary treatments should not exist. President Clinton has endorsed federal legislation that would make such clauses illegal. Enactment of such legislation is an administration priority.

HCFA's action applies to more than 4.7 million Medicare beneficiaries enrolled in managed care plans.

Managed Care Options Have Been Expanded for Medicare Beneficiaries

The Clinton Administration recently announced that Medicare beneficiaries in Orlando, Fla., Philadelphia, Pa., Houston, Tex., and rural southern Virginia can begin the New Year by choosing to enroll in new types of managed care plans. The new plans are being made available under Medicare through a demonstration recently begun by HCFA.

The Medicare Choices demonstration is designed to give beneficiaries expanded choices among types of managed care plans and to test new ways to pay for managed care. As of January 1, 1997, beneficiaries in the four areas can choose from among the newer types of managed care plans now available under Medicare.

The plans include four provider sponsored networks (PSNs), one preferred provider organization (PPO), and a "triple option" hybrid plan. The hybrid plan lets beneficiaries use a "gatekeeper" physician in the plan, see other providers in the plan's network without going through the gatekeeper, or go outside the network. In all six plans, payments by Medicare will be adjusted according to the health status of beneficiaries, instead of considering only demographic factors.

Beneficiaries around the country currently can obtain managed care through more than 300 health maintenance organizations that participate in Medicare. "Choices" demonstration sites are in targeted market areas that were chosen because they currently have limited enrollment in managed care. An additional 13 sites are expected to begin enrollment later in 1997.

Selected Sites Targeted for Demonstration Project

The number of Medicare beneficiaries voluntarily choosing managed care has been growing by 80,000 each month. Nearly five million of Medicare's 38 million beneficiaries have chosen to join managed care plans.

Outreach Educates Hispanics about Medicare in Texas

HCFA's Dallas Regional Office is working with local health affiliates in an effort to educate the Hispanic beneficiaries about the Medicare program. Specifically, Blue Cross/Blue Shield of Texas is offering Spanish versions of "Welcome to Medicare" seminars and educational programs focusing on heart disease, diabetes, participating and non-participating physicians. The carrier is also planning to televise videos on those subjects on local cable networks. Customer service representatives who are fluent in Spanish are available to answer telephone inquiries from Spanish-speaking individuals.

In addition, the Texas Medical Foundation has carried out "Adelante Con Su Salud" — a program to increase flu immunization of Hispanic beneficiaries in three local counties. Staff in the HCFA Regional Office recently participated in a Hispanic Media Fair in the Dallas/Fort Worth area. The fair included a panel discussion with local Hispanic members of the television, radio, and printed media as well as informational booths.

Medicaid Health Reform Waiver Approved for Alabama

The State of Alabama has been approved to operate a unique Medicaid reform demonstration project in Mobile County. Medicaid beneficiaries in Mobile County will be enrolled in the BAY Health Plan. The waiver allows beneficiaries to choose their primary care providers within the network at any time. Medicaid providers, and any provider meeting the State's criteria as specified in the BAY Health Plan's contract are included in the network. Primary providers in the network are the University of South Alabama Hospitals, affiliated outpatient centers, the College of Medicine, and Federally Qualified Health Centers. The BAY Health Plan will provide all mandated Medicaid benefits without any co-payments, deductibles, or cost-sharing. It will offer an enhanced family planning service for low-income women — expanding the eligibility period from the current 60-day postpartum up to 24 months.

HCFA Administrator Bruce C. Vladeck said that HCFA worked closely with the State to develop assurances for beneficiaries who will be enrolled in a single, at-risk managed care plan. He further stated that the Alabama waiver includes components that have not been replicated in any other State health reform demonstration.

Browse HCFA's Web Site

Visit HCFA's home page on the World Wide Web at

http://www.hcfa.gov

to learn the latest news and information on the Medicare and Medicaid programs. After you finish browsing our web site, be sure to bookmark the URL so that you can quickly reach HCFA's home page for future reference.

Organ Transplant Hearing

(Continued from page 1)

The topics discussed at the hearing are primarily the responsibility of the Health Resources Services Administration, yet HCFA plays a role in organ transplantation by paying for approximately 14,000 organ transplants each year. HCFA is interested in the allocation process and is working with other DHHS components to ensure that Medicare and Medicaid beneficiaries retain access to scarce organs. HCFA also establishes Medicare participation standards for organ procurement organizations and transplant facilities.

Message from the Administrator

(Continued from page 2)

❒ *Providing side-by-side comparison charts for Medicare managed care plans.* We have been providing these charts in some geographic areas. This year we are implementing a more systematic approach, adopting standardized language along with other refinements that make the charts easier to understand. The charts will be posted in an electronic format that is easy and economical to use and update.

❒ *Establishing national HMO marketing guidelines for Medicare.* We put out these guidelines so that seniors will know everything they need to know before enrolling in a managed care plan. The guidelines also help managed care plans by clarifying what they must do to comply with regulations on marketing to Medicare beneficiaries.

Key Regulations/Notices

MEDICARE PROGRAM; CHANGES CONCERNING SUSPENSION OF MEDICARE PAYMENTS, AND DETERMINATIONS OF ALLOWABLE INTEREST EXPENSES (BPO- 118-FC)—PUBLISHED 12/2 This rule revises the Medicare regulations on suspension of Medicare payments and determination of allowable interest expenses. These changes are being made to conform the regulations with law and established policy, to protect the Government's interests.

MEDICARE PROGRAM; CHANGES TO THE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEMS AND FISCAL YEAR 1997 RATES; CORRECTIONS (BPD- 847-FCN)—PUBLISHED 12/19 In the August 30, 1996, issue of the *Federal Register* (61 FR 46166), we published a final rule revising the Medicare hospital inpatient prospective payment systems for operating costs and capital-related costs to implement necessary changes arising from our continuing experience with the system. In the addendum to that final rule on prospective payment rates for Medicare hospital inpatient service we announced the amounts and factors applicable to discharges occurring on or after October 1, 1996, and rate-of-increase limits for hospitals and units excluded from PPS. This rule corrects errors made in the document.

MEDICARE PROGRAM; RECOGNITION OF THE AMBULATORY SURGICAL CENTER STANDARDS OF THE JOINT COMMISSION ON THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS AND THE ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE (BPD-849-FN)—PUBLISHED 12/19 This notice grants "deemed" status to the Joint Commission on the Accreditation of Healthcare Organizations and to the Accreditation Association for Ambulatory Health Care, for their accredited ambulatory surgical centers requesting Medicare certification.

THREE-AGENCY NOTICE ON HEALTH INSURANCE PORTABILITY—PUBLISHED 12/30 The Department of Health and Human Services' Health Care Financing Administration (HCFA), Department of Labor's Pension and Welfare Benefits Administration, and Department of the Treasury's Office of Tax Policy and Internal Revenue Service, have received comments from the public on a number of issues arising under the portability, access, and renewability provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This notice advises the public that further comments are welcome before April 1, 1997.

MEDICARE AND MEDICAID PROGRAMS; REQUIREMENTS FOR PHYSICIAN INCENTIVE PLANS IN PREPAID HEALTH CARE ORGANIZATIONS (OMC-010- F)—PUBLISHED 12/31 This final rule amends the regulations governing physician incentive plans operated by Federally Qualified Health Maintenance Organizations and competitive medical plans contracting with the Medicare program, and certain health maintenance organizations and health insuring organizations contracting with the Medicaid program.

NOTIFICATION PROCEDURES FOR STATES IMPLEMENTING "ALTERNATIVE MECHANISMS" IN THE INDIVIDUAL HEALTH INSURANCE MARKET (BPD-882-N)— PUBLISHED 1/13 This notice describes the statutory provisions under section 111 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that guarantee availability of individual health insurance coverage to certain individuals with prior group coverage. It also provides procedural guidance for States that intend to implement an alternative mechanism under section 111 of HIPAA. Finally, this notice describes the statutory provisions that will apply in a State that does not implement an acceptable alternative mechanism.

MEDICAID PROGRAM; REDETERMINATIONS OF MEDICAID ELIGIBILITY DUE TO WELFARE REFORM (MB-105-FC)—PUBLISHED 1/13 The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 created changes in Federal law affecting the eligibility of many Medicaid recipients. These changes include revisions to the definition of disability for children and to the eligibility requirements of non-U.S. citizens and individuals receiving disability cash assistance based on alcoholism and drug addiction. This final rule with comment period protects Federal financial participation (FFP) in Medicaid expenditures for States with unusual volumes of eligibility redeterminations caused by these recent changes. This rule makes changes to the regulations to provide for additional time for States to process these redeterminations and provide services pending the redeterminations.

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